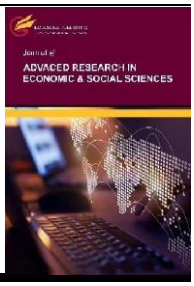
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A CRITICAL REVIEW OF PROFESSIONAL IDENTITY, COMPETENCY FRAMEWORKS AND WORKFORCE MANAGEMENT IN THE HEALTH PROMOTION WORKFORCE

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Abstract: Health promotion is studied intensively as a set of interventions and scarcely at all as a form of work. This critical review reconstitutes the people who deliver health promotion as an occupational category and asks what is known about their professional identity, competencies, remuneration, supervision and retention. Drawing on 94 sources spanning health promotion competency and accreditation scholarship, community health worker research in low- and middle-income countries, and the sociology of professions, it argues that the field studies two workforces, a small, credentialed specialist cadre in high-income Anglophone systems and a large, largely unpaid and majority-female frontline cadre in the Global South, never analysed together although they perform overlapping work. Four findings follow. First, sixteen years of competency framework development has produced frameworks but almost no evaluation, and the field's own scoping review found only two instances of evaluation across thirty-nine sources. Second, a European framework was relabelled global in 2016 without re-derivation, while the corresponding low- and middle-income scoping study was published as a report rather than in the peer-reviewed record. Third, nobody can count this workforce; Nigeria's own health promotion policy mandates a census of health promotion officers that remains unpublished. Fourth, where the workforce is counted it is frequently unpaid, with fifty-nine per cent of unsalaried community health worker cadres meeting published criteria for labour exploitation against ten per cent of salaried ones. The review argues that competency frameworks constitute professionalism imposed from above without occupational control, proposes an occupational viability framework organised around enumeration, jurisdiction, compensation and voice, and sets out a research agenda prioritising enumeration studies and African evidence.
Key words: Health promotion workforce; professional identity; competency frameworks; community health workers; workforce management; sociology of professions

1.0 Introduction

Health promotion is among the most theorised fields in public health. Four decades after the Ottawa Charter it possesses a settled conceptual vocabulary, an extensive intervention literature, a mature critique of individualism, and a strong tradition of attending to the social determinants of health. What it does not possess is a body of knowledge about the people who do the work. Health educators, health promotion officers, community health workers, health extension workers and community health extension workers appear across thousands of studies as delivery mechanisms, characterised by dose, coverage, fidelity and cost per contact. They appear very rarely as workers with careers, supervisors, salaries, grievances, professional associations and reasons for leaving.

The omission is consequential. Health systems do not implement interventions; people do, under employment conditions that determine whether the intervention survives contact with a district. A behaviour change programme delivered by an unpaid volunteer expected to work more than forty hours a week is a different object from the same programme delivered by a salaried officer with a supervisor and a career ladder, even when the protocol is identical. Yet the evaluation literature routinely treats these as the same intervention, and the resulting evidence base is systematically silent about the labour conditions on which its own findings depend.

1.1 Two workforces that are never studied together

Reading across the literature reveals not one workforce but two, described in separate bodies of scholarship that do not cite one another.

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The first is the specialist health promotion workforce: credentialed practitioners, usually holding a postgraduate qualification, employed in health departments, non-governmental organisations and local government, concentrated in Ireland, the United Kingdom, Australia, New Zealand, Canada and parts of continental Europe. This is the workforce addressed by the Galway Consensus Conference (Allegrante et al., 2009), the CompHP project (Barry et al., 2012), and the IUHPE accreditation system (Battel-Kirk et al., 2015, 2021). Its literature is preoccupied with competencies, standards, accreditation and professional recognition.

The second is the frontline community health workforce: community health workers, health extension workers, accredited social health activists and equivalent cadres, numbering in the millions, predominantly female, frequently unpaid or paid through performance incentives, concentrated in low- and middle-income countries. This is the workforce addressed by the World Health Organization guideline on optimising community health worker programmes (Cometto et al., 2018; WHO, 2018) and by an extensive literature on motivation, incentives, attrition and supervision (Kok et al., 2015; Scott et al., 2018; Ballard et al., 2023). Its literature is preoccupied with performance, retention and cost.

These two workforces perform substantially overlapping work. Both conduct community engagement, health education, behaviour change communication, outreach and advocacy. Both mediate between formal health systems and populations. Both occupy subordinate positions relative to medicine and nursing. Yet the competency literature almost never discusses community health workers, and the community health worker literature almost never engages with health promotion competency frameworks. The consequence is that arguments developed in one, about professional identity, credentialing and jurisdiction in the first, and about remuneration, gender and exploitation in the second, are never brought to bear on the other. This review's central move is to read them together.

1.2 Purpose and contribution

This paper is a critical review in the sense specified by Grant and Booth (2009): it appraises a body of work, identifies its most significant contributions and structural weaknesses, and produces a conceptual contribution rather than an answer to a narrow effectiveness question. It makes four contributions. Conceptually, it constitutes the health promotion workforce as a single occupational object spanning both cadres. Evaluatively, it audits the evidence produced by sixteen years of competency framework development and finds it thin, self-referential and geographically narrow. Theoretically, it argues that the field has applied an individual-attribute model, competence, to what is an occupational-structure problem, and imports the sociology of professions to correct this. Practically, it proposes an occupational viability framework and a research agenda, with particular attention to Nigeria and sub-Saharan Africa.

2.0 Statement of the Problem

Health promotion policy in many countries now specifies a credentialed health promotion cadre. Nigeria's revised National Health Promotion Policy states that health promotion programmes across all tiers of government shall be led by qualified health promotion specialists, and sets minimum qualifications including a master's degree in health promotion at national and state level and a degree or diploma at local government level (Federal Ministry of Health, 2019). The same policy concedes that professional health promoters are in short supply in both quantity and quality, and mandates a census to generate a comprehensive inventory of health promotion officers. No published enumeration resulting from that mandate could be located for this review.

That gap between a policy that names a profession and an evidence base that cannot count it defines the problem. Three features make it urgent. First, the international competency and accreditation infrastructure on which national policies increasingly draw was derived in Europe, and was relabelled global in 2016 without being re-derived for other contexts (IUHPE, 2024); its own architects' evaluation found roughly half of an insider sample reporting non-use nine years after publication (Battel-Kirk & Barry, 2020). Second, where the workforce actually exists at scale, it exists in a form the competency literature does not describe: unsalaried, majority-female, and in a majority of unsalaried cadres meeting published criteria for labour exploitation (Ballard et al., 2023). Third, the theoretical apparatus the field uses, competence as an individual attribute, cannot address questions of jurisdiction, closure and occupational control that determine whether an occupation survives at all, as the dissolution of England's specialist health promotion workforce demonstrates (Duncan, 2013).

Constituting the health promotion workforce as a single occupational object, auditing what is actually known about it, and specifying what would have to be studied for the field to become useful to health managers and workforce planners, is therefore the problem this review addresses.

2.1 Objectives of the Study

The objectives of this review are as follows.

i. Characterise how the health promotion workforce has been defined, enumerated and described across the specialist and community health worker literatures.

ii. Appraise the evidence generated by international health promotion competency and accreditation frameworks, including its geographical reach and its evaluative depth.

iii. Examine what is known about the management of this workforce, specifically remuneration, supervision, workload, career progression, gender relations and attrition.

iv. Evaluate the adequacy of the field's theoretical apparatus and propose an alternative framework and research agenda for occupational analysis of health promotion work.

2.2 Research Questions

The following research questions guided the review.

1. How is the health promotion workforce defined and enumerated, and by whom?
2. What evidence exists that international competency and accreditation frameworks have changed practice, and where geographically does that evidence come from?
3. What does the literature establish about the employment conditions of those who deliver health promotion, particularly remuneration, supervision, workload and attrition?
4. Which theoretical frameworks are used to analyse this workforce, and are they adequate to the occupational level at which the problem operates?

3.0 Methodology

3.1 Review type and its justification

Grant and Booth's (2009) SALSA typology distinguishes fourteen review genres by their approach to Search, AppraisaL, Synthesis and Analysis. Three considerations rule out a conventional systematic review. First, the object has no shared vocabulary: the same worker is indexed variously as a health promotion practitioner, health educator, health promotion officer, community health worker, lay health worker, close-to-community provider, health extension worker, community health extension worker or accredited social health activist, across health promotion, human resources for health, global health, medical sociology and public administration. Second, the corpus is heterogeneous by design, comprising Delphi consensus exercises, competency frameworks, accreditation pilots, discrete choice experiments, quasi-experiments, qualitative interview studies, ethnographies, systematic reviews, meta-reviews, national policy documents and commissioned workforce reports, with no common effect measure and nothing to pool. Third, the review's purpose is appraisal and reconceptualisation rather than aggregation, which is the condition under which Grant and Booth locate the critical review and which Torraco (2005) describes for the integrative review, a genre whose output is a new conceptualisation of a body of work rather than a summary of it. Snyder's (2019) guidance on semi-systematic and integrative designs supplied the procedural discipline.

The review is therefore reported as a critical, configurative review, transparent about search and selection in the spirit of PRISMA 2020 (Page et al., 2021) without claiming its exhaustiveness. SPIDER (Cooke et al., 2012) rather than PICO structured the question, since the evidence of interest is occupational and largely qualitative.

3.2 Search strategy

Searches were run across PubMed and PubMed Central, Crossref, DOAJ, ERIC, Google Scholar and publisher platforms including Oxford Academic, SAGE Journals, Springer Nature Link, Wiley Online Library, Elsevier and BioMed Central, supplemented by citation chaining in both directions and by targeted retrieval of policy and grey literature from the World Health Organization, the International Union for Health Promotion and Education and national health ministries. Four search clusters were combined with Boolean operators and truncation. Cluster A (specialist workforce) combined “health promotion workforce” OR “health promotion practitioner” OR “health educator” with competenc* OR accreditation OR credential* OR professionali*. Cluster B (frontline workforce) combined “community health worker” OR “lay health worker” OR “health extension worker” OR “close-to-community provider” with motivation OR retention OR attrition OR remuneration OR incentive* OR supervision OR workload. Cluster C (occupational theory) combined “sociology of professions” OR jurisdiction OR “occupational closure” OR “professional identity” OR “emotional labour” OR “invisible work” with health OR “public health” OR “allied health”. Cluster D (regional) combined the workforce terms with Nigeria OR Ghana OR Ethiopia OR “South Africa” OR “sub-Saharan Africa” OR “low- and middle-income”.

3.3 Inclusion, appraisal and corpus

Sources were included where they addressed the health promotion or community health workforce as an occupational category rather than solely as an intervention delivery channel, or where they supplied theoretical or methodological apparatus for such analysis. Peer-reviewed work published between 2000 and 2026 was prioritised, with seminal earlier work retained where genealogically necessary (Abbott, 1988; Bourdieu, 1986; Etzioni, 1969; Freidson, 1970/1988, 2001; Hochschild, 1983; Larson, 1977; Lipsky, 2010). Policy documents and commissioned workforce reports were retained where they contained enumeration attempts or cadre specifications unavailable in the peer-reviewed record, and are identified as such throughout rather than cited as empirical findings.

Appraisal was conducted narratively against four criteria: whether the workers themselves were among the informants; whether employment conditions, including pay, were reported alongside performance; whether the study enumerated or merely described the workforce; and whether findings were generated in, or merely transferred to, the setting to which they were applied. Ninety-four sources are cited, comprising 31 addressing health promotion competencies, accreditation and specialist workforce studies, 29 addressing community health workers and frontline workforce management, 11 reporting African or Nigerian evidence specifically, and 23 supplying theoretical and methodological anchors.

3.4 Theoretical lens

The field's dominant analytic device is the competency: a specified, assessable attribute of an individual practitioner. Competency frameworks answer the question of what a practitioner should be able to do. They cannot answer the questions that determine whether an occupation survives: who is entitled to do this work, who pays for it, and who decides. This review therefore imports four theoretical anchors from the sociology of professions and adjacent traditions.

Abbott's (1988) system of professions supplies the concept of jurisdiction: professions exist in an interdependent system competing for control over problem areas, with claims contested in workplace, public and legal arenas. Waring and Martin (2025) demonstrate the concept's contemporary purchase, showing through the notions of demonstrable claims and jurisdictional clipping how subordinate health occupations expand into the parts of a care pathway that dominant professions decline to work, which is arguably health promotion's structural position exactly. Larson's (1977) professional project supplies the complementary concept of market closure: the collective mobilisation through which scarce expertise is converted into social and economic reward. Etzioni's (1969) semi-profession, with its shorter training, supervised rather than autonomous practice and absence of protected privilege, names the position health promotion occupies, although the category's gendered assumptions require it to be used critically rather than descriptively.

Evetts (2011, 2013) supplies the distinction on which this review's central argument turns: between occupational professionalism, constructed from within an occupational group and entailing collegial control over the division of labour, and organisational professionalism, a discourse of standards, targets and audit imposed from above by managers. Evetts (2013) further shows how professionalism functions as an ideology securing discretionary effort without commensurate reward, which is directly applicable to a workforce widely described as vocational and widely unpaid. Freidson (2001) frames professionalism as a third logic of occupational control, distinct from market and bureaucracy, prompting the question of whether health promotion exercises any control over its own division of labour or is governed wholly by the bureaucratic logic of employers and commissioners.

Three further anchors address why the work is undervalued rather than merely subordinate. Hochschild's (1983) emotional labour names the unpriced relational work of community engagement and behaviour change practice. Star and Strauss (1999) explain how work becomes invisible within representational and indicator regimes, a mechanism extended empirically to a low-status health occupation by Ming et al. (2023); work that does not appear in performance metrics is easy to cut. Bourdieu's (1986) forms of capital explain why institutionalised cultural capital in the form of health promotion credentials converts poorly into occupational status and pay. Finally, Lipsky's (2010) street-level bureaucracy establishes that frontline workers exercising discretion under caseload pressure are de facto policymakers, and Link and Phelan's (1995; Phelan et al., 2010) fundamental cause theory establishes that the individual behaviour change work for which health promotion is most often commissioned is theoretically mismatched to the causes of the inequalities it is asked to reduce, a mismatch that destabilises the occupation's own warrant.

4.0 Results: Thematic Synthesis

4.1 Sixteen years of competency development and almost no evaluation

The competency project is the field's principal collective effort at professionalisation. It began with the Galway Consensus Conference, which set out eight domains of core competency for health promotion and health education and framed the exercise as international collaboration among IUHPE, SOPHE, AAHE and NCHEC (Allegrante, Barry, Airhihenbuwa et al., 2009; Barry et al., 2009) and reviewed three years later (Allegrante, Barry, Auld, & Lamarre, 2012), supported by a review of the existing competency literature (Battel-Kirk et al., 2009) and by an explicit argument for cross-national credentialing (Allegrante, Barry, Auld, Lamarre, & Taub, 2009). It continued through the CompHP project, which produced eleven core domains and sixty-eight competency statements via Delphi surveys across thirty countries, focus groups with twenty-five leaders, consultation with one hundred and sixteen practitioners and online feedback from fifty-four respondents (Barry et al., 2012), accompanied by professional standards (Speller et al., 2012) and a pan-European accreditation framework developed with four hundred and five participants across twenty-nine countries (Battel-Kirk, Van der Zanden et al., 2012). It has continued to the present through a scoping-review-based revision of the global framework (Harte et al., 2025).

The evidence that any of this changed practice is remarkably thin, and the most damaging appraisals come from the framework's own architects. Battel-Kirk and Barry's (2019a) scoping review of whether health promotion competencies had made a difference examined thirty-nine sources published between 2009 and 2017, of which twenty-six were theoretical and thirteen empirical. Most merely presented frameworks or described their development. The authors identified only two instances of evaluation of competencies in the entire literature. Their subsequent uptake survey drew eighty-one responses from twenty-five European countries through a purposive and snowball sample of people already involved with CompHP; even within that insider sample, only fifty-three per cent reported that the competencies were used in their country and only fifty-four per cent used them in their own practice, with use concentrated in education rather than practice, and lack of recognition by key organisations identified as a potentially critical factor (Battel-Kirk & Barry, 2020). A paired case study in Ireland and Italy, drawing on twenty-six interviews, found lack of awareness of the competencies to be a major limiting factor in both countries, of particular concern in relation to employers and decision-makers (Battel-Kirk & Barry, 2019b). The accreditation system's own pilot processed applications from twenty health promotion practitioners, two education programmes and one national accreditation organisation across the whole of Europe, with stakeholders naming absence of dedicated practitioners and professional bodies, lack of clarity about professional boundaries, and concerns about cost, objectivity and transparency as barriers (Battel-Kirk et al., 2015).

Two structural observations follow. The first concerns authorship. Substantially the same small team has authored the founding framework, the accreditation system, the scoping review evaluating whether the framework worked, the survey measuring its uptake, the case study of its implementation, the commentary reporting its positive impact (Battel-Kirk et al., 2021) and the current revision. This is not an accusation of bad faith; it is a description of an evaluative loop with no independent external assessment, and a field should notice when its principal quality-assurance infrastructure is appraised exclusively by the people who built it. The second concerns evidentiary weight. Twenty accredited practitioners in a pan-European pilot, and one hundred and sixteen practitioners consulted for a framework covering a continental workforce, are numbers that would not sustain a claim about a population in any other area of public health research.

4.2 The enumeration problem: a workforce nobody can count

Underlying the thinness of the competency evidence is a more basic failure. There is no reliable count of the health promotion workforce anywhere. Watts et al. (2020) systematically reviewed eighty-two publications that enumerated a public health workforce between 2000 and 2018 and found that most workforce definitions were unique and study-specific, built around occupation or place of work, and that there are very few regular, consistent enumerations within countries and fewer still capturing a substantial proportion of the workforce. Health promotion practitioners barely register as an enumerated occupational category in that review, which is itself the finding.

Attempts at enumeration illustrate the difficulty. An Australian mapping exercise of the preventive health workforce cited an earlier estimate of between one thousand three hundred and two thousand people derived from professional body memberships, concluded that it was impossible to estimate the size of the indirect workforce, and proceeded by two regional case studies rather than a national count (Ryan et al., 2014). Earlier Australian and New Zealand workforce studies surveyed training needs, research use, recruitment and turnover without establishing a denominator (Swerissen & Tilgner, 2000; James et al., 2007; Lovell et al., 2015). Nigeria's National Health Promotion Policy mandates a census of health promotion officers (Federal Ministry of Health, 2019); no published result of that census was located.

Czabanowska et al. (2024), reviewing professionalisation of the wider public health workforce against the WHO-ASPHER roadmap's five levers of competencies, education, formal organisation, credentialing and codes of conduct, found only eleven articles across sixty-one countries meeting inclusion criteria between 2016 and 2022. About half provided any definition of the public health workforce; more than half addressed taxonomy or competences, but formal organisation and codes of conduct were acknowledged in only two studies. Their conclusion, that professionalisation is fragmented and not fully recognised or supported, applies with greater force to health promotion specifically.

An occupation that cannot be counted cannot be planned for, budgeted for, or defended when budgets contract. This is not a technical inconvenience; it is a condition of occupational vulnerability, and it connects directly to Star and Strauss's (1999) account of how work disappears from indicator regimes.

4.3 Where the specialist cadre is absent, other occupations do the work

The most direct evidence on who actually delivers health promotion in low- and middle-income settings comes from studies of other occupations. Enebeli et al. (2024), interviewing ten nurses across eight rural primary health care facilities in eight local government areas of Anambra State, Nigeria, found nurses describing themselves as facilitators of behavioural and environmental change, empowerment facilitators and social activists, while identifying insufficient funding, poor working conditions, staff shortages, high workload, lack of training opportunities and low community participation as inhibiting factors. Orok et al. (2026) document Nigerian pharmacists undertaking health promotion activity. Ajisegiri et al. (2023), studying hypertension and diabetes care across four Nigerian states through a survey of seventy-six community health workers, thirteen focus groups with ninety participants, and interviews with thirteen community health workers and seven government stakeholders, found that these workers frequently delivered services beyond the scope of practice set out in the National Standing Orders, an informal and unauthorised expansion driven by the absence of higher cadres.

Read against the policy that specifies a master's-qualified health promotion specialist in every state (Federal Ministry of Health, 2019), the picture is of a jurisdiction claimed on paper and occupied in practice by nurses, pharmacists and community health extension workers doing the work without the title, the training or the mandate. In Abbott's (1988) terms this is not merely a workforce shortage; it is a failed jurisdictional claim, in which the occupation named in policy has neither secured the work nor conceded it, and the practical settlement is made informally at facility level. Okoroafor et al. (2022), applying the workload indicators of staffing needs method across one hundred and ninety-six primary health care facilities in Cross River State, quantify the underlying scarcity: forty per cent of required nurses and midwives were available and sixty per cent of required community health officers and community health extension workers, with substantial task overlap between cadres.

4.4 Remuneration, gender and the volunteer economy

Where the workforce does exist at scale, its defining feature is that much of it is not paid. Ballard et al. (2023), reviewing one hundred and seventeen reports from one hundred and twelve studies across nineteen countries, found that thirteen of twenty-two unsalaried community health worker cadres, fifty-nine per cent, met their criteria for labour exploitation, against one of ten salaried cadres, ten per cent. Three of eighteen unsalaried cadres were expected to work more than forty hours per week without pay. Non-payment, unreliable incentives and excessive workload were the drivers. Wennerstrom and Smith (2023) argue in an accompanying commentary that this is a structural feature of programme design rather than an incidental failure.

The gender dimension is inseparable from this. Steege et al. (2018), combining a review of fifty-eight papers with primary qualitative research in six countries, identify safety and well-being, remuneration and career progression as the priority gender-equity issues for close-to-community providers. Closser et al. (2019), working with unpaid female volunteers in Ethiopia's Women's Development Army between 2013 and 2016, found some gains in mobility and self-actualisation but no ability to exercise political power and no compensation, and argue that empowerment discourse allows governments to claim gender gains without paying fair wages. Closser et al. (2023) document gendered harassment and assault of female community health workers, from communities and from supervisors, systematically downplayed in programme design and monitoring. Marwah (2026), drawing on eighty interviews across twelve months of ethnographic fieldwork with India's accredited social health activists, finds that workers overwhelmingly read incentive-based payment as a status marker rather than fair pay, experiencing it as stigmatising relative to a salary.

The evidence on what payment structures achieve is more nuanced than either advocates or sceptics allow. Ormel et al. (2019), comparing salaried and volunteer cadres across six countries, found that expectation gaps, meaning lower-than-promised or delayed payments, demotivated both, and concluded that consistently receiving the type and amount of incentive promised matters as much as the absolute level. Saran et al. (2020), through a discrete choice experiment with one hundred and ninety-nine community health workers across thirty-two Kenyan communities, found high community appreciation valued equivalently to a monthly transport allowance of about twenty United States dollars. Okech et al. (2025), in a five-arm quasi-experiment with one thousand one hundred and four community health workers across five Ugandan districts, found moderate performance-based components of thirty to fifty per cent of pay produced the best coverage and motivation, while a seventy per cent performance-based structure increased stress and reduced retention. Singh et al. (2015) and Colvin et al. (2021) similarly find that well-trained, supervised and adequately remunerated workers engage in genuine community empowerment work, while commodity-selling and thinly incentivised volunteers do not.

The finding that recurs across this literature is that payment adequacy, predictability and form each matter independently, and that none of them appears in any health promotion competency framework. Competence is specified in detail; the conditions under which competence can be exercised are not specified at all.

4.5 Supervision, workload and task accretion

Supervision is the intervention the literature most consistently recommends and least convincingly evidences. Hill et al. (2014), reviewing twenty-two impact studies, found that improving supervision quality has a greater effect than increasing frequency, but that the underlying evaluation methodology was weak. Vasan et al. (2017), scoping forty papers on support and performance improvement for primary health care workers, concluded that despite a large supervision literature there is little clarity on what defines the most effective approach. Ballard and Montgomery (2017), synthesising fourteen randomised controlled trials, identify recruitment, supervision, incentivisation and equipment as the four modifiable levers of performance. Bhatnagar et al. (2017), interviewing twenty-nine primary health workers and nine government officials in Nasarawa and Ondo States, found local supervision by the officer-in-charge more effective than external agency supervision, alongside vocation, religion and community recognition as motivators.

Workload is better evidenced and worse addressed. Astale et al. (2023), in a mixed-methods systematic review, found that forty-two of forty-three included studies, ninety-eight per cent, reported high workload among community health workers, with thirty-three studies documenting multiple simultaneous tasks. This is the arithmetic of vertical programming: each new priority adds tasks to the same person, and no programme removes any. Mijovic et al. (2016), reviewing health workers' experiences of task shifting in sub-Saharan Africa, document jurisdictional disputes over cadres working beyond their scope of practice and unresolved tensions over compensation and career development, alongside negative effects on the agency of the cadres from whom tasks were shifted. Coales et al. (2023), synthesising fifty-four studies, find that task shifting succeeds only with preparatory training and sustained resource access, and is otherwise absorbed as unfunded additional burden.

Attrition is the visible consequence. Nkonki et al. (2011) argued that lay health worker attrition is important but often ignored, and that its magnitude, determinants and remedies are all unresolved. Ethiopia supplies the most complete national picture: Tekle et al. (2022) found actual attrition among health extension workers of twenty-one per cent with a median time to exit of 5.8 years and a current intention to leave of nearly forty per cent, driven by low incentives, absence of career development, high workload and psychosocial factors; Wolde et al. (2023), tracking three thousand four hundred and seventy-six workers over fifteen years, confirmed overall attrition of twenty-one per cent, found that seventy-three per cent of leavers exited the health system entirely, and documented extreme regional variation from 38.5 per cent in Addis Ababa to 6.1 per cent in Harari. Ngilangwa and Mgomella (2018), studying three hundred and forty-one Tanzanian community health workers, found retention predicted by marriage, prior volunteer experience and prior employment, and negatively associated with being female, a finding that should be read alongside the harassment evidence rather than as a characteristic of women.

4.6 The professionalisation paradox

The obvious remedy, professionalise the workforce, is more contested than it appears. A live disagreement runs through the recent literature. Ballard et al. (2025) argue that the word professional, meaning salaried, skilled, supervised and supplied, should be attached to community health workers in all policy language as a precondition for universal health coverage. Miranda et al. (2025) propose adding security, in the form of formal contracts, as a fifth pillar of professionalisation, noting that most community health workers still work without any contractual agreement. Tikkanen (2025) responds that a contract alone is insufficient and that formalisation, meaning recognition within statutory workforce structures and labour law, is the necessary second pillar of job security.

Against this, Logan (2021) demonstrates empirically that formal professionalisation through certification and standardisation simultaneously secures recognition and erodes the community-rootedness that gave the role its value, a double-edged sword. Golden and Bencherki (2024) theorise community health workers as liminal professionals, holding both institutionally valued technical knowledge and devalued communicative and community knowledge, and locate their boundary insecurity in that duality. The history is not encouraging either: Duncan (2013) traces how health promotion in England failed to professionalise and struggled to specialise between 1980 and 2000, with the specialist workforce subsequently dissolved; Warwick-Booth et al. (2019) and White and Wills (2011) document the paradox of a strengthening evidence base alongside a weakening occupational position; Woodall and Freeman (2020) argue that persistent ambiguity in conceptual foundation, practice and education is contributing to health promotion's decline in several parts of the world. Sunderland et al. (2015) document moral distress among practitioners in Canada and Australia when institutional roles conflict with professed values, and Wallace et al. (2026), interviewing nineteen community-based practitioners in Western Australia, name the resulting paradox precisely: practitioners tasked with promoting health work under conditions that erode their own health, well-being and professional values.

Read through Evetts (2011, 2013), the pattern resolves. What the competency and accreditation infrastructure has produced is organisational professionalism: a discourse of standards, domains and audit, applied to practitioners from above, without any corresponding grant of occupational control over entry, scope or the division of labour. Practitioners acquire the obligations of a profession without its protections. The effect reaches into training: Blackford et al. (2024), tracking Australian undergraduates against the IUHPE competencies, found students strong on social responsibility but weak on the political engagement dimensions, which is what one would expect of a framework specifying individual attributes rather than collective occupational agency. Biehl et al. (2025), analysing professionalism in health promotion through seven aspects comprising knowledge base, field of action, education, professional association, competencies, professional identity and professional practice, name the CompHP framework a milestone while identifying major remaining gaps including no unity on the content and level of education. Van den Broucke (2021) puts the underlying tension well in arguing that health promotion's contribution lies in the complementary nature of specialist and mainstreamed practice: an occupation that is simultaneously a speciality and everybody's business has, in Larson's (1977) terms, no basis on which to effect closure. Bourdieu's (1986) account of capital convertibility completes the explanation: a credential that no employer requires and no statute protects is institutionalised cultural capital that will not convert.

4.7 The African evidence and the transfer problem

Evidence from Africa is scarce, and what exists documents both weak capacity and a pattern of model transfer. Rwafa-Ponela et al. (2021), assessing health promotion capacity in the South African Department of Health through five workshops with twenty-eight staff at national, provincial and district level, recorded an overall self-assessed capacity mean of 2.08 out of 4.00, with limited capacity to develop sustainable interventions, limited national-provincial collaboration, limited monitoring of health promotion indicators in the health information system, intersectoral coordination largely absent and budgeting capacity a major gap; the authors note explicitly that evidence on health promotion capacity in low- and middle-income countries is limited. Wills and Rudolph (2010) and Nyamwaya (2003) provide the earlier baseline.

The transfer pattern is visible in the titles themselves. Boboko et al. (2023), studying seventeen participants comprising eight health promoters, six operational managers and three senior managers in a South African National Health Insurance pilot district, found workforce structure and policies deficient, managerial supervision and monitoring lacking, resources insufficient, and barriers outnumbering enablers, and titled the paper Health Promotion Workforce in South Africa: Direction from the Australian Health Promotion Association. The instinct to import an Anglophone workforce model into an African health system is precisely what Tiwari et al. (2022) argue against in calling for global health competencies for the African region to be re-envisioned in line with local health needs and resources rather than transferred. Moreira and Machado (2020) show what the alternative looks like in practice, developing a matrix of essential health promotion competencies specifically for the Brazilian context rather than adopting CompHP.

Two features of the international infrastructure sharpen the point. The IUHPE's own framework document records that the competencies were renamed the IUHPE Core Competencies in 2016 when the accreditation system expanded to the global level (IUHPE, 2024): a European framework became a global one by renaming, not by re-derivation. And the scoping study of health promotion workforce capacity and training needs in low- and middle-income countries was published in the IUHPE research report series (Battel-Kirk & Barry, 2011), while the European work occupied a peer-reviewed journal special issue. Where the evidence was placed reflects where the field's attention was.

5.0 Discussion

5.1 An occupational viability framework

The synthesis suggests that the field has been asking the wrong question. It has asked what competencies a health promotion practitioner should possess, a question that presupposes a stable occupation into which competent individuals can be inserted. The prior question is whether the occupation is viable at all. The framework proposed here specifies four conditions, drawn from the theoretical anchors in Section 3.4, each of which is necessary and none of which is addressed by competency frameworks.

Enumeration asks whether the workforce can be counted and named in official statistics, following from Star and Strauss (1999): work that is invisible in indicator regimes cannot be defended in a budget cycle. Jurisdiction asks whether there is a

defended domain of work that this occupation and no other is entitled to perform, following Abbott (1988) and Larson (1977). Compensation asks whether the labour is paid, predictably, at a level commensurate with its demands, following Ballard et al. (2023) and Evetts (2013). Voice asks whether the occupation exercises collegial control over entry, scope and standards, or receives them from employers, following Freidson (2001) and Evetts (2011). Table 1 applies the four conditions to both cadres.

Table 1

Occupational Viability Framework Applied to the Two Health Promotion Workforces

Condition	Diagnostic question	Specialist health promotion cadre	Community health worker cadre
Enumeration	Can the workforce be counted and named in official statistics?	No. Definitions are study-specific; the largest national estimate rests on professional body membership (Ryan et al., 2014; Watts et al., 2020).	Partially. Programme rosters exist, but attrition and informal substitution are poorly captured (Nkonki et al., 2011; Wolde et al., 2023).
Jurisdiction	Is there a defended domain of work this occupation alone may perform?	No. Claimed in policy, occupied informally by nurses, pharmacists and other cadres (Duncan, 2013; Enebeli et al., 2024).	No. Scope is set by programmes, not by the occupation; workers routinely exceed it (Ajisegiri et al., 2023; Mijovic et al., 2016).
Compensation	Is the labour paid, predictably, at a level commensurate with its demands?	Usually salaried but funded through short cyclical grants, producing churn (Lovell et al., 2015; Wallace et al., 2026).	Frequently not. 59% of unsalaried cadres meet criteria for labour exploitation (Ballard et al., 2023; Closser et al., 2019).
Voice	Does the occupation control entry, scope and standards, or receive them?	Receives them. Competency and accreditation systems are organisational, not occupational, professionalism (Evetts, 2011; Battel-Kirk & Barry, 2020).	Receives them. Contracts are largely absent and representation is rare (Miranda et al., 2025; Tikkanen, 2025).

The table's diagnostic value lies in the pattern it exposes. Neither cadre satisfies any of the four conditions, but they fail differently and for different reasons, and each cadre's literature has developed sophisticated instruments for the conditions the other neglects. The specialist literature has the vocabulary of jurisdiction and voice but no engagement with pay; the community health worker literature has rigorous evidence on compensation and workload but treats professional identity as a motivation variable rather than a structural question. Reading them together is not an academic convenience; it is the only way to assemble a complete diagnosis.

5.2 A research agenda

The following eight propositions are stated so as to be falsifiable and are ordered by urgency.

1. Enumeration. A systematic attempt to enumerate the health promotion workforce in any low- or middle-income country will find that the number of practitioners holding the qualifications specified in national policy is an order of magnitude smaller than the number of people performing health promotion functions.
2. Substitution. Where a specialist health promotion cadre is absent, its functions will be absorbed informally by nurses, pharmacists and community health extension workers without adjustment to their scope of practice, workload allowance or remuneration.
3. Framework non-adoption. Adoption of international health promotion competency frameworks in African health systems will be concentrated in university curricula and largely absent from employer job descriptions, recruitment criteria and performance appraisal.
4. Compensation form. Holding total remuneration constant, salaried employment will outperform incentive-based payment on retention and on worker-reported dignity, consistent with the status-marker reading of incentive pay.
5. Predictability. Variance in payment timing will predict attrition more strongly than the absolute level of payment.
6. Task accretion. The number of vertical programmes assigned to a frontline worker will predict intention to leave independently of pay and supervision.
7. Organisational professionalism. Practitioners working under competency-based appraisal without collegial control over scope will report higher role ambiguity and moral distress than those in occupations with statutory registration.
8. Invisibility. Health promotion posts will be disproportionately represented among posts abolished during health budget contractions, relative to posts whose outputs appear in routine health information systems.

The agenda requires, minimally: national enumeration studies using a stated occupational definition, beginning with the census Nigeria's own policy already mandates; longitudinal cohort studies of practitioners rather than cross-sectional attitude surveys; evaluations of competency frameworks conducted by researchers independent of the framework developers; economic evaluation comparing compensation models on total cost including replacement and retraining after attrition; and African-led competency derivation of the kind Tiwari et al. (2022) call for and Moreira and Machado (2020) demonstrate, rather than adaptation of imported frameworks.

5.3 Limitations

This review is bounded in four ways. It is English-language only, which is a material limitation given that relevant scholarship exists in French for francophone Africa, in Portuguese for Brazil and Mozambique, and in Spanish for Latin America; the same restriction in Battel-Kirk and Barry's (2019a) scoping review is one mechanism by which the field's Anglocentrism reproduces itself, and this review reproduces it too. Several publisher platforms and bibliographic services intermittently

refused programmatic access during searching, so a minority of bibliographic details were verified through PubMed, Crossref, DOAJ and institutional repositories rather than publisher records; sources whose details could not be resolved were excluded rather than cited. As a critical rather than systematic review it makes no exhaustiveness claim and reports no inter-rater reliability, since screening and appraisal were narrative and single-reviewer. Finally, treating the specialist and community health worker cadres as one occupational object is an analytic decision, not an established fact; readers who regard them as genuinely distinct occupations will read the synthesis as a comparison rather than an integration, and that reading is defensible.

6.0 Conclusion

Health promotion has spent four decades theorising the social determination of health and almost no time theorising the social determination of its own work. This review has argued that the people who deliver health promotion constitute an occupational category that the field has never properly constituted: uncounted, jurisdictionally undefended, frequently unpaid, and professionalised from above through competency frameworks that specify obligations without conferring control.

The picture is not one of an ineffective workforce. Community health workers demonstrably improve coverage and outcomes; specialist practitioners demonstrably possess sophisticated skills. It is a picture of a field that has invested sixteen years in describing what its practitioners should be able to do while leaving unexamined whether they are paid, whether they are counted, whether anyone is obliged to employ them, and whether they have any collective say in the answers. Those omissions are not incidental to effectiveness; they are the mechanism by which effective programmes lose their workforce.

The questions are, recognisably, social science questions, and health promotion is unusually well equipped to ask them. A field that has taught public health to see how poverty, gender and power shape the health of populations is capable of seeing how the same forces shape the working lives of the people it sends into those populations. The most useful thing it can do now is not to publish another competency framework, of which there are already more than there are evaluations, but to turn its own analytic instruments on itself.

7.0 Recommendations

Based on the findings of this review, the following recommendations are made.

1. Ministries of health should execute the workforce enumerations their own policies already mandate, using a stated occupational definition, and should publish the results; in Nigeria, the census of health promotion officers required by the National Health Promotion Policy is the immediate priority.
2. Health promotion posts and functions should be made visible in routine health information systems and workforce registries, since work that generates no recorded output is disproportionately exposed when budgets contract.
3. Competency frameworks should not be adopted from international sources without local derivation, and should be accompanied by employer-side obligations, meaning job descriptions, recruitment criteria and appraisal standards that actually reference them, without which they remain curricular documents.
4. Where community health workers are relied upon for health promotion delivery, they should be salaried rather than incentivised, on predictable schedules, with written agreements specifying responsibilities and worker rights, and with explicit protection against the harassment the evidence documents.
5. Programme managers should treat task accretion as a managed quantity, auditing the cumulative workload imposed on frontline workers when new vertical programmes are introduced, and removing or resourcing tasks rather than adding them indefinitely.
6. Professional associations and regulators should pursue occupational control, including scope definition, statutory registration where feasible and collective representation, alongside competency specification, since competence without closure produces obligations without protection.
7. Research funders and journals should commission independent evaluation of health promotion competency and accreditation systems by researchers unconnected to their development, and should prioritise African-led workforce research over the transfer of Anglophone workforce models.

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